HARBOR REHABILITATION
REFERRAL FORM

SUBMITTED BY: ______________________

CONTACT NUMBER: ______________________

DATE: ______________________

CLIENT NAME:	
ADDRESS: **HOME PHONE/CELL PHONE:** **EMAIL:**	**BIRTHDATE (AGE):** **SOCIAL SECURITY NUMBER:** **MARITAL STATUS:** **SEX:**

MEDICAL/BACKGROUND INFORMATION	√	**SERVICES NEEDED:**	**FREQUENCY/ DURATION:**
Diagnosis: **Date of Injury:** **Background Information (or attach/fax):**		Physical Therapy	
		Occupational Therapy	
		Speech/Language Pathology	
		Social Work	
		Recreational Therapy	
		Home Accessibility Evaluation	
		Attendant Care/Supervision Evaluation	
		Other:	

PRIMARY INSURANCE (check below):				**SECONDARY INSURANCE (if applicable)**			
Auto	Health	Workers Comp.	Private Pay	Auto	Health	Workers Comp.	Private Pay

NAME: **ADDRESS:** **CONTACT PERSON:** **PHONE/FAX/EMAIL:** **GROUP/POLICY NUMBER:** **CLAIM NUMBER:**	**NAME:** **ADDRESS:** **CONTACT PERSON:** **PHONE/FAX/EMAIL:** **GROUP/POLICY NUMBER:** **CLAIM NUMBER:**

ORDERING PHYSICIAN	**PRIMARY CARE PHYSICIAN**
PHYSICIAN NAME AND ADDRESS: **PHONE/FAX:**	**PHYSICIAN NAME AND ADDRESS:** **PHONE/FAX:**

CASE MANAGER	**OTHER PROVIDER (i.e. nursing)**
CASE MANAGER NAME AND ADDRESS: **PHONE/FAX/EMAIL:**	**NAME AND ADDRESS:** **PHONE/FAX/EMAIL:**

Please fax completed form to: 616.643.0844, or send via email to: info@harborrehab.com